



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

GUSTAVO BUENTELLO, MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-0519-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

OCTOBER 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The procedure code provided on the claim is correct and should be a covered expense by the insurance."

Amount in Dispute: \$419.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DWC60 packet contains evidence of only one bill submission and no evidence a request for reconsideration was submitted to Texas Mutual. For its part Texas Mutual only has the one bill in its claims processing system and no record of receiving an appeal."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 9, 2014	CPT Code 97750 Physical Performance Test	\$419.40	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.250 sets out the guidelines for reconsideration of a medical bill.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
 - CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - 213-The charge exceeds the schedule value and/or parameters that would appear reasonable.
 - 729-This bill was reviewed in accordance with your First Health Contract.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Did the requestor submit timely reconsideration prior to requesting Medical Fee Dispute Resolution (MFDR)?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. A review of the submitted explanation of benefits does not support a Preferred Provider Organization (PPO) or contract discount was taken. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable division rules and guidelines.
2. On the disputed date of service, the requestor billed CPT code 97750-MT for 8 units.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The respondent asserts that the request for medical fee dispute resolution should be dismissed because "DWC60 packet contains evidence of only one bill submission and no evidence a request for reconsideration was submitted to Texas Mutual. For its part Texas Mutual only has the one bill in its claims processing system and no record of receiving an appeal."

A review of the submitted documentation finds:

- HCFA-1500 dated June 23, 2014 stamped "ORIGINAL".
- HCFA-1500 dated September 29, 2014.
- Letter requesting reconsideration dated September 25, 2014.
- Request for medical fee dispute resolution (MFDR) was received by MFDR on October 6, 2014.

28 Texas Administrative Code §133.250(g) states "The insurance carrier shall take final action on a reconsideration request within 30 days of receiving the request for reconsideration."

The respondent indicated in the position summary that they did not receive the bill requesting reconsideration. The Division finds that the requestor did not support position that disputed bill was submitted for reconsideration nor was the respondent given 30 days to take final action on the reconsideration bill prior to seeking MFDR.

28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."

28 Texas Administrative Code §133.307(c)(2)(J) states in pertinent part, "Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include... (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)."

28 Texas Administrative Code §133.307(c)(2)(K) states "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." The requestor did not submit a copy of the reconsideration EOB or convincing evidence of insurance carrier receipt of the request for an EOB.

The Division finds that the request for medical fee dispute resolution was not filed in the form and manner required by 28 Texas Administrative Code §133.307(c)(2)(J) and (K).

28 Texas Administrative Code §133.307(f)(3)(A) states “The division may dismiss a request for MFDR if: (A) the division determines that the medical bills in the dispute have not been submitted to the insurance carrier for an appeal, when required.” The submitted documentation does not support that the medical bills in the dispute were submitted to the respondent for reconsideration; therefore, the requestor failed to comply with 28 Texas Administrative Code §133.250 and §133.307. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	05/06/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.